Please read the Terms, Conditions and Instructions on the back of this form prior to completing the form.

Georgia Department of Community Health
State Health Benefit Plan
Retirement/Surviving Spouse Form

Mail to: State Health Benefit Plan
P.O. Box 38342
Atlanta, Georgia 30334-0342

I. Member Identification

Social Security Number ___ – ___ – ____

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence | County Code

Date of Birth: Month | Day | Year

Daytime Telephone Number ( )
Area Code

Sex (Check one): ☐ Male ☐ Female

II. Coverage Action

☐ Enrollment in Retirement System
- ☐ Service Retirement
- ☐ Disability Retirement
- ☐ Surviving Spouse/ Dependent (Last Payroll Deduction Date not applicable)
- ☐ Soc. Sec. # of Deceased ___ – ___ – ____

Last Payroll Deduction Date		
Month	Day	Year

☐ Change of Coverage Option

☐ Change of Coverage Type

Check the box that best describes the reason for this membership action and give the date of the event. These actions require supporting documentation.

- ☐ Marriage
- ☐ Divorce
- ☐ Death of Dependent
- ☐ Acquisition of Dependent
- ☐ Change of Spouse's Employment

Date of Event		
Month	Day	Year

Which Retirement System will provide benefits? _____

III. Coverage

Check your choice of one of the coverage options available to you. Also check your choice of coverage type.

- ☐ PPO (58)
- ☐ PPO CCO (68)
- ☐ BlueChoice (06)
- ☐ BlueChoice CCO (16)
- ☐ CIGNA (05)
- ☐ CIGNA CCO (15)
- ☐ Kaiser (07)
- ☐ Kaiser CCO (17)
- ☐ Kaiser Medicare Advantage (27)
- ☐ United Healthcare (03)
- ☐ United Healthcare CCO (13)
- ☐ Indemnity (89)
- ☐ Tricare Supplement (02)-Deers#_____(required)
- ☐ High Deductible Plan (08)
- ☐ High Deductible Plan CCO (18)

IV. Retirement System Use Only

Date of First Deduction	Month	Day	Year	Retirement System No.		Retiree Number	

Type: ☐ Single (10) ☐ Family (20)

V. Dependents and Medicare

See reverse side of this form for dependent eligibility requirements. Coverage for all dependents requires submission of additional documents; coverage will not begin until documentation is received and approved. "Not Entitled" for Medicare means that neither you nor your spouse have contributed to Social Security in order to make you eligible.

Use these codes to show the relationship of each dependent

SP for your wife or husband | SC for your stepchild
NC for your natural child | LC legal child

Full name of persons to be covered: Last, First, Initial	Relationship (See above)	Sex (Circle)	Date of Birth: Month	Day	Year	Social Security Number	Medicare	Effective Date	Medicare Number
Retiree (Same as Above)	SELF						Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No Part D ☐ Yes ☐ No	A B D	
		M F					Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No Part D ☐ Yes ☐ No	A B D	
		M F					Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No Part D ☐ Yes ☐ No	A B D	

VI. Authorization

I have read and agree to abide by the terms and conditions on the back of this form. I hereby authorize the retirement system to deduct each month from any benefit due me the premium amount applicable to the coverage I have selected. I understand that my eligibility for the State Health Benefit Plan is contingent on continuous coverage. I agree to pay directly for any lapse of coverage caused by administrative delay. I also understand that I cannot change coverage except under limited conditions as stated on the back of the form. If I have selected an HMO and the HMO ceases operation, I authorize the State Health Benefit Plan to automatically transfer my coverage to the PPO, unless I make another coverage selection as allowed by the Plan. I hereby certify that the above information and any supporting documentation is true and correct. I understand that misrepresentation or falsification will subject me to penalties and possible legal action.

Signature: _____ Date: _____

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

This form must be used by a retired or retiring State Health Benefit Plan (SHBP) member, or surviving spouse/dependent(s), who will be receiving an annuity from one of the following retirement systems: Teachers' Retirement System, Employees' Retirement System, Legislative Retirement System, Superior Court or District Attorneys' Retirement System or any local school system's retirement system. The annuity must be in sufficient amount to pay the premium deduction amount for health benefit coverage. Effective date of the change is dependent on payroll deadlines and information provided. Refunds will not be issued for late submission or incorrect information. You must apply for continued coverage for yourself and covered dependents within 60 days of the date your active coverage ends.

Review the instructions and conditions under each Section. The retiree or surviving spouse/dependent must complete Sections I, II, III, and V. Please read the authorization carefully before signing and dating the form in Section VI.

Enrollment for Coverage

Coverage for a retired employee, teacher, or surviving spouse/ dependent(s) must be continuous. If the annuity payment from your retirement system does not begin immediately, your coverage will be interrupted. To protect your eligibility for coverage, the SHBP eligibility office should be contacted for instructions concerning alternative payment provisions allowed by the Plan.

The surviving spouse may elect to continue coverage for surviving eligible dependent children. No additional dependents may be covered at this time or in the future. Dependent children may continue coverage until such time as they no longer meet the eligibility requirements which are listed in the Eligible Dependents Section.

A surviving spouse who is also eligible for coverage under the Plan as a retiree or employee may elect coverage as a surviving spouse or employee. Such persons cannot elect double or dual coverage under these separate provisions of the Plan. The surviving spouse may resume coverage upon termination of employment if otherwise ineligible for coverage as a retiree.

Surviving dependent children may continue coverage until such time as they no longer meet the eligibility requirements which are listed in the Eligible Dependents Section

Retirees who return to state employment in a benefits-eligible position must discontinue retiree coverage and elect coverage as an employee. When active employment terminates, the retiree may resume coverage as a retired member with premiums deducted through their retirement annuity.

Eligible Dependents

Be sure to use the proper code to describe the dependent's relationship to you in Section V of the form. The following sections describe dependents who are eligible for coverage.

A) SP - Your legal spouse as defined by Georgia law - Copy of certified marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) with financial information blacked out and showing the spouse's signature.

B) NC - Natural Child - Copy of the certified birth certificate showing parents names.

C) SC - Step Child - Copy of certified birth certificate showing your spouse is the natural parent: AND Copy of certified marriage license showing the natural parent is your spouse; AND Notarized statement that the dependent lives in your home at least 180 days per year.

D) LC - Other child (which includes adoptions and temporary and permanent guardianship) - Copy of court decree showing your financial responsibility for the dependent; AND copy of certified birth certificate; AND notarized statement that dependent lives in your home on a permanent basis.

E) Your never married dependent children ages 19 through 25, who are otherwise eligible under categories B, C, or D and who are registered students in regular full-time attendance at an accredited school, college or university, or institution for the training of nurses. A Student Status information form (SHBP 66-082) will be forwarded to you for any dependent child age 19 through 25 listed in Section V. Coverage for your full-time student(s) will be updated after receipt of the required documentation. Dependent children ages 19 through 25 who are employed in benefits eligible positions are not eligible for coverage regardless of student status.

VERY IMPORTANT: DEPENDENTS MUST BE VERIFIED PRIOR TO THEIR COVERAGE EXPIRATION DATE. Students, Disabled Children and Legal Children recertification must be received before the coverage expiration date. Dependents will not be eligible after the expiration date, if documentation is not received before their coverage expires.

Medicare Information

Medicare information for retirees and their covered dependents has a direct relationship to the rate that will be charged for health coverage and the benefits paid; therefore, accurate Medicare information must be provided by the member.

- If you or any of your covered dependents have enrolled in Medicare, circle Yes in Section V and provide all of the information requested. Attach a copy of the Medicare Card.
- If you or any of your covered dependents are not eligible to receive Medicare benefits at the time of your retirement because of their age, circle No in Section V of the form.

Eligibility to Change Coverage

Retirees and surviving spouse/dependents may change to any available option during the annual Retiree Option Change Period. However, retirees and surviving spouses/dependents without SHBP coverage will not be permitted to enroll for health coverage during this period.

<u>Change of Option</u>

- At the time of enrollment as a retiree, a change may be made to any available option.

<u>Change of Coverage Type</u>

- A CHANGE from Family to Single coverage is allowed upon request.
- RETIREES are allowed to CHANGE from Single to Family coverage upon acquisition of a dependent by marriage, birth, adoption, a qualified medical child support order (QMSCO) or for certain other changes in family status (see the Eligible Dependents Section), provided the request is filed no later than 31 days following the event. Surviving spouses/dependents are not allowed to change from Single to Family coverage.
- If you are changing from Single to Family Coverage due to the acquisition of a dependent (including a spouse), it is your responsibility to notify the Plan if your Dependent has other health benefit coverage. If you are covered by the PPO, PPO Choice, or Indemnity, you should contact the claim and benefit office to provide the other insurance information. If you are covered by one of the HMO options, please contact that HMO directly to provide the other insurance information.
- RETIREES are allowed to CHANGE from Single to Family coverage upon the loss of dependent's health benefit coverage through Medicaid, Medicare, the group or COBRA coverage of the spouse or former spouse, provided the request is filed no later than 31 days following the event. Attach a letter from Medicaid, Medicare, or the spouse's or former spouse's employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.

Penalties for Misrepresentation of Information

The Commissioner of the Department of Community Health or a designee is empowered to investigate any membership or dependent coverage records and, upon discovery of any misrepresentation of fact, is empowered to terminate the coverage, or reverse the change in coverage and seek recovery of any funds paid from the SHBP as a result of the misrepresentation.